Presentation to the Regulatory Reform Committee
Michigan House of Representatives
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Members of the Committee,

Thank you for the opportunity to make a statement to you today regarding Senate Bill 577.

As you know, this piece of legislation would prohibit any health professional found to have committed as sexual offense against a patient from ever having his/her license to practice reinstated.

This legislation is part of a huge systematic effort at the State and federal levels to use regulatory law to impose the most severe lifelong punishments on all persons convicted of sex offenses, many of whom are trying to lives their lives safely and responsibly. These laws include those that prohibit sex offenders from living and working in many communities, having gainful employment, receiving education at institutions of higher learning, receiving housing assistance, receiving food assistance, having access to public transportation, and living free from fear of harassment, prejudice and vigilante justice. These laws are very popular politically, but have been shown in numerous studies to do far more harm than good in protecting the public and lowering crime rates. They trample on the basic rights of a certain group of citizens who suffer from sexual behaviors disorders. The laws are largely driven by fear and outrage created by popular misconceptions and stories in the media about the most dangerous offenders.

While Senate Bill 577 on the surface would appear to be justified to protect the public from dangerous health care professionals, it would fail to balance public safety with other crucial rights and principles written into the State Constitution, our democracy and social values. These principles include basic fairness, due process, and restorative justice. Senate bill 577, moreover, is inconsistent with the human potential for redemption, change, growth, recovery and rehabilitation. This law is completely out of sync with current findings from scientific studies of recidivism and the potential for offenders to recover and to serve the public safely and effectively.

This legislation prefers to use regulatory rules as a form of automatic punishment and public protection through permanent exclusion for all health care professionals who commit sexual misconduct. It seems to forget that the criminal justice system is already designated to provide the punishments and protections by removing the most dangerous offenders from society often for many years at a time. While riding high on the principle of toughness and extremism to protect the public, this legislation is terribly unfair to a certain minority of individuals. These are individuals who suffer from a behavioral disorder, commit an offense, lose their license to practice for several years, are punished for several years, have genuine remorse, undergo extensive and successful treatment, become capable of practicing safely and responsibly, desire to return to public service as a professional, and have a role in serving the public. I assert that

these few individuals can be reliably differentiated from those who remain dangerous and that they should in some cases be given a second chance to serve the public as health care professionals.

There are multiple ways in which Senate bill 577 blatantly conflicts with the findings from studies on sex offenders, as I mentioned. These studies show that sex offenders are a very diverse group and that each case must be evaluated individually and thoroughly. Specifically, Senate Bill 577 fails to consider the following findings:

1. That certain offenders have genuine remorse and are very committed to recovery.
2. That sexual offending is a behavioral disorder that is treatable with currently available evidence-based behavioral approaches.
3. That certain offenders are successful in reaching their treatment goals of being safe and responsible.
4. That some offenders are high risk or dangerous, while others are low- risk or situational offenders.
5. That the overall recidivism rates of sex offenders in general are low.
6. That certain subgroups are especially low-risk.
7. That objective risk assessment methods are now available to help determine the actual risk level in any given case of an offender.
8. Finally, that there are victims of sex offenses who engage in a process of recovery, and in fact, do not object to the person who harmed them from eventually re-integrating into society as professionals as long as they are carefully monitored and demonstrate that they will be safe.

The implication from these findings are that some identifiable ex-sex offenders could have a role to play in helping others without ever harming another individual. I assert that certain ex-offenders could at least partially make amends for prior bad acts by using his/her skills and abilities to safely help others.

In Michigan, very few health care professionals who commit sexual offenses with patients ever have their licenses restored. I know of no other psychologist who has been restored after a serious sexual offense besides myself. In my case, I was severely punished with over 13 years in prison. I continued in therapy for the entire time I was there rather than limiting myself to the required one year program. I underwent extensive psychological evaluations by two psychologists who testified at my hearing before the administrative law judge regarding the restoration of my license. I was assessed for my risk level using actuarial testing. I was extensively assessed for my behavior in recovery, level of remorse, honesty, willingness to take responsibility for my offenses, and my relapse prevention plan.

After my hearing, the Licensing Board required that I pass the national licensing exam, undergo extensive retraining, be closely supervised and have my license restricted for 3 years. Since being reinstated, I have practiced providing intensive counseling to adults with severe drug addiction and mental disorders in the City of Detroit. I have worked hard every day to provide them with the most advanced forms of cognitive-behavioral therapy and have received consistently excellent performance evaluations over the last three years. I am the only

psychologist practicing at the agency where I work, and many of the individuals we treat have been to prison and involved in criminal behavior. Many others have been victims of crime including sex crimes. I know the criminal justice system and criminal world far better than any mental health professional I know. I believe there is place for a certain ex-offenders who are in recovery in the world of professional health care. However, Senate Bill 577 would prohibit them from having this opportunity.

There are much more reasonable alternatives to Senate Bill 577 that would give the Licensing Board and Administrative Law system new guidelines and options to carefully assess each offender for genuine rehabilitation based on objective evidence. The Board could require the offender demonstrate extensive rehabilitation through two comprehensive psychological assessments by forensic psychologists specializing in sex offenders. It could also require the offender successfully undergo extensive therapy with a professional specializing in treating sex offenders.

I am submitting three sets of guidelines of programs used currently in other states that are to treat professionals who commit sexual misconduct. The first is an outline of the Professional Sexual Misconduct Treatment Program, which is directed by Dr. Scott Stacy of the Professional Renewal Center in Lawrence, Kansas. Second, I have submitted an outline of the Professional Sexual Misconduct Treatment Program of Drs. Richard Kruger, Meg Kaplan and Douglas Martinez at Columbia University, New York. Finally I am submitting an outline of the program of Dr. Gene Abel at the Behavioral Medicine Institute in Atlanta.

These are comprehensive modern treatment programs. Please take a few minutes to review the outlines I have submitted. The Licensing Board's in Michigan could modify their procedures and update their approaches by borrowing heavily from these models, requiring the same level of extensive evaluation and treatment for the offenders in Michigan. For example, the Board in Michigan could require the use of objective risk assessment measures, such as the Static 99 or the Sex Offender Risk Assessment Guide. The offenders could have a license suspended or revoked for at least extensive periods of time while the offender is undergoing treatment, before regaining eligibility for a restricted or limited license to practice under careful, close supervision.

These are much more flexible, fair and scientifically-grounded approaches than the simplistic, extreme one taken in Senate Bill 577. This approach is much more consistent with the recovery model advocated by the Substance Abuse Mental Health Administration and the recovery model adopted formally by the State of Michigan several years ago. This model asserts that many people can and do recover from behavior disorders if given the help they need. In the case of professionals who commit sex offenses, a few will be deemed dangerous and ineligible for reinstatement, while others recovery to be safe and competent. All should be taken on his or her own merits and progress in recovery, and all should have their fundamental rights upheld.

As a final point, I would like to point out that Senate Bill 577 uses a standard of judgment that no-one would ever apply to themselves. Take the worst act a person has committed and judge him or her only on the basis of that behavior, ignoring everything else about that person life, especially attempts at redemption, change and improvement and other qualities of character. Using this model, no one would ever qualify to be a teacher, judge, lawyer, dentist, physician,

psychologist, police officer, or legislator. We simply don't judge others in this biased fashion in a rational society. Please don't judge sex offenders in this extreme manner unless you are willing to apply the same standards to you own lives.

Thank you for the opportunity to make this presentation today. If there is any way I can be of assistance in the creation of a rational and informed policy for professional sexual misconduct, I would be honored to do so.

Respectfully, submitted,

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The Misuse of Power: Professional Sexual Misconduct

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1) What is a boundary?

Within the context of clinical practice, a boundary is the containing *edge* of appropriate behavior (Gutheil and Gabbard, 1993). In the doctor-patient relationship the establishment of clear boundaries is intended to create a safe and predictable place where treatment can unfold. The doctor-patient relationship is made unique by the doctor always carrying the burden for maintaining appropriate boundaries in the service of the patient's healing. This burden stems from the power differential inherent in the doctor's role and function as healer.

A boundary can also be conceptualized as a frame in which treatment is provided. Just as the surgeon creates a sterile field in which to cut, so as to reduce the chance of introducing a potentially contaminating element, chiropractors must also function within a treatment frame in order to assure the sanctity of their work. When the frame is broken or altered in any manner, the doctor's role and function has been altered, in practice *and* in the mind of the patient, and a shift in the doctor-patient relationship has occurred.

2) What is transference and countertransference and why is it important to attend to these concepts in the doctor-patient relationship?

Over the course of our development, we internalize and create a complex set of interpersonal templates that structure the way in which we perceive, experience, and respond to those around us. There are a wide variety of emotions that are linked to our formative relationships. Thus, both positive and negative feelings color those templates through which we make meaning out of our interpersonal world. Because the doctor-patient interaction is a relationship, regardless of the content of the technique or treatment engaged in, our templates from the past structure every interaction we have with patients.

When the patient's templates of relating become activated toward the doctor, we call this transference. When the doctor's templates of relating become activated toward the patient, we call that countertransference. The nature of transference and countertransference is unconscious and ubiquitous in clinical practice; that is, we are

usually not cognizant of the phenomena that seamlessly structures meaning in all of our relationships. Inevitably, doctors and patients experience positive, negative, neutral or erotic/romantic feelings toward each other. Various emotions such as sexual feelings, anger, and frustration can color the doctor-patient relationship. This is normal. However, when these emotions go unchecked, they can have a life of their own. The doctor-patient relationship is ripe for evoking powerful transference enactments. This is because the doctor-patient relationship mirrors in many ways those of childhood. In the simplest of terms, you have the doctor who is cast in the role of an authoritative figure with power (a parent) and a patient who is cast in the role of someone in need (a child). Feelings and wishes from the past can become unconsciously evoked and enacted between doctor and patient in the present. Transference phenomena is made manifest in the form of behaviors. Examples may include: the healthy provision and acceptance of services, spending extra time with patients, flirting, avoiding certain patients, and the temporary loosening of professional boundaries.

Boundary transgressions and violations are transference/countertransference dynamics that have gone awry. Falling in love with a patient, sexual involvement, engaging in personal heroics (rescuing), and loaning money to a patient are examples of unchecked, pathological expressions of countertransference.

3) Types of boundary problems:

a. ***Boundary blurring*** occurs when the doctor steps outside of his/her typical role as a clinician and functions in some other capacity. For example, allowing a patient to use the office phone to call the auto club to jump his/her car. Or, perhaps under certain circumstances buying Girl Scout cookies from a patient's daughter. Boundary blurring neither exploits or harms the patient and sometime can even benefit the doctor-patient relationship. The important fact to remember when blurring boundaries is that you have altered the treatment frame in some manner and the possible consequences (positive and negative) of doing so need to be appreciated.

b. ***Dual relationships*** occur when the doctor becomes confused about his/her role. Dual relationships typically involve the doctor playing two or more roles in relation to the patient simultaneously. Examples would include engaging in non-clinical business transactions with patients, loaning or borrowing money, befriending patients or supervising a patient in some capacity, while also retaining the role of doctor with the patient.

c. ***Sexual impropriety*** occurs when the doctor makes sexually provocative, demeaning or explicit comments about a patient's body or clothing. (Gabbard and Nadelson, 1995).

d. ***Boundary transgressions*** are exploitive and refer to the doctor touching a patient in an explicit or circuitous manner that does not include blatant sexual relations. For example, kissing or the fondling of a patient's body parts (e.g.,

frotteurism) are considered to be a transgression of patient boundaries (Gabbard and Nadelson, 1995).

c. ***Sexual violations*** are considered to be the most damaging of boundary incursions. This type of conduct involves explicit sexual involvement including sexual intercourse, oral sex, anal sex, and mutual masturbation (Gabbard and Nadelson, 1995).

d. ***The slippery slope*** is a term used to capture how a doctor can lose his/her footing at the edge of the clinical boundary and unknowingly slide into a set of interpersonal circumstances that eventually become unethical. One unknowingly slides down the slope toward unethical conduct when the warning signs go unheeded (e.g. unaccounted for boundary blurring, role confusion, disclosing personal information, purposefully meeting in a social context, not charging for services or flirting).

4) Assessing the complainant's credibility:

Usually, the opportunity to assess the complainant's or doctor's credibility emerges during initial contact or when reading the investigator's report.

a. When talking with the complainant, compassionately explore the facts. Let the complainant tell her/his story in an uninterrupted manner. Important to consider is that a biased interview or report by an investigator can color the facts. Remember, boundary violations can evoke strong feelings, which if left unchecked can influence one's understanding of the facts.

b. If reluctant to discuss details, address the issue of shame and self-blame if appropriate. Discuss the power dynamics inherent in the doctor-patient relationship and how the ethical covenant between them may have been disturbed. Address the issue that the doctor needs to get help because his behaviors are indicating that he is in trouble. Help the alleged victim to understand that they might not be the only recipient of the doctor's inappropriate conduct.

c. To assess the complainant's credibility, examine the internal consistency of his/her story after s/he has an opportunity to tell her complete story. Are there any inconsistencies? What are they? Can they be resolved? Discontinuities can be the sign of a lack of accuracy or even dishonesty. Be careful not to "lead the witness." Is there a common reoccurring theme or pattern of the doctor's behavior across different complainants? Is their story believable at face value or outlandish?

5) Assessing the doctor's credibility:

a. Examine the internal consistency of the doctor's story. Are there any discontinuities? If so, when do they occur and what are they? Can they be

reconciled? Inconsistencies can be the sign of a lack of accuracy or even dishonesty. Be careful not to lead the doctor in the discussion. Let him/her respond. Ask them to reconcile inconsistencies. If they are unable to do so, it is likely that they are not being fully truthful. Does the doctor degrade, blame or demean the complainant? This can sometimes be indicative of a personality disorder.

b. How well does the doctor's story line up with the complainant's story? How do they differ? Can these differences be reconciled? If not, it could mean that the doctor is either purposefully lying or reluctant to disclose the truth. It is possible that certain incidents did not occur or the complainant may be exaggerating or lying.
c. Thoroughly check the doctor's alibi(s).

d. Review the doctor's medical records/documentation. Look for inconsistencies.

e. Request a polygraph. If the doctor is open to undergoing a polygraph, this can sometimes be indicative of credibility.

6) Various outcomes of initial contact:

a. Sometimes the doctor will be forthcoming and his/her story will line up with the patient's. When this occurs, a thorough assessment is needed to determine his/her rehabilitation potential. Sometime boundary cases become civil cases and judgments are made in court regarding damages. Punitive action by the Board is often taken (the professional voluntarily surrenders his/her license, suspension or revocation). If deemed a good candidate for treatment and the risk for reoffense is low, treatment can be carried out and a plan for reentry can be constructed.

b. Sometimes the patient will admit that the allegations are false. The case is dismissed.

c. Sometimes a case can become imprisoned in a "he said/she said" deadlock, where both sides contain some merit of truth. In these instances, a thorough professional assessment of the doctor along with the administration of a polygraph can be helpful.

7) The assessment process:

a. Levels of Intervening
    1. If the nature of the boundary problem is non-exploitive, such as attending a social event with a patient without having overt sexual contact, assessment may be able to be completed by a local clinician such as a

psychologist or psychiatrist who has a history of working with doctors who have engaged in professional misconduct.

2. A thorough five-day multidisciplinary assessment is indicated in most boundary cases.

   The central goal of any multidisciplinary assessment and/or treatment program should be to promote adherence to ethical conduct and personal growth for doctors. The multidisciplinary approach offers a number of safeguards for doctors and the referral source that individual or solo practice assessments may not be able to offer.

   Making important decisions about public safety, the status of a doctor's license, and livelihood is best made when numerous disciplines are involved. An appropriate team approach includes a psychologist, psychiatrist, physician, social worker, and an addictions expert. The problem of bias can be sharply reduced by involving more than two people in the assessment, because each participant contributes different diagnostic perspectives. The team of professionals should have a well-established track record of assessing and treating healthcare professionals.

   At PRC, we use a data convergence model to understand those we assess: we look at points of data from different disciplines and observe how these data intersect. This assures the team a high degree of accuracy in terms of diagnostic specificity, which then translates into sound recommendations

b) Clinical elements of a thorough assessment:

1. A medical evaluation can help to rule out an underlying medical condition that could have predisposed the doctor to boundary violations (e.g., the abuse of testosterone and the sequelae of some chemotherapy agents can cause emotional/sexual disinhibition and clouded judgment. Endocrine (thyroid) imbalances can lead to depression and poor judgment).

2. A thorough psychiatric assessment is employed to explore the possible convergence of medical and psychological problem(s) that predispose the doctor to engage in a boundary violation (BPD). The psychiatric assessment also aids in screening for substances of abuse and severe psychopathology that could be rooted in a neurotransmitter dysfunction.

3. Psychological testing needs to be employed to screen for: 1) cognitive/ neurological impairment or thought disorder; and 2) a mood disorder (BPD), psychosis, PTSD, anxiety disorder, impulse control disorder, ADHD, sexual addiction or substance abuse/dependency. The ruling out

of predatory intent, sexual disorders and other severe forms of personality psychopathology are also important. The psychological testing also helps the assessment team to develop an explanatory hypothesis.

4. Establishing a biopsychosocial explanatory hypothesis helps the assessment team and the referral source to understand the conscious, and underlying unconscious, psychological conflicts, vulnerabilities, and psychopathology that predisposed the doctor to engage in professional sexual misconduct. For example, the doctor may be unknowingly reenacting a traumatic event from the past, repeating a pattern of self-defeating behavior, struggling with marital discord, which can lead to a combination of professional burnout and entering into an affair with a patient (love sickness). The explanatory hypothesis also helps the team to estimate under what conditions the doctor may become vulnerable to re-offend and what type of treatment interventions are needed to offset that risk.

5. The administration of a polygraph, if indicated.

6. A complete analysis of developmental, social, and religious history to explore how developmental problems/vulnerabilities from the past have led to the progression of psychological problems in the present. A careful analysis of the doctor's childhood and professional development can aid in the team's ability to construct a sound explanatory hypothesis.

7. Behavioral observations of the doctor within the context of peers who are also being assessed or who are in treatment helps to relax the doctor's defenses, permitting him/her to be more forthcoming (provide an example of peer confrontation).

8. The careful review and analysis of collateral information (e.g., victim statement, investigation reports, prior assessments) is an essential component of the assessment process. It provides the important voice of the victim to be heard over the course of the assessment. It also provides the treatment team with the opportunity to consider other peoples' perspectives (spouse, colleagues, former assessment teams, etc.).

9. The multidisciplinary team meeting is the crucible into which all the information from the assessment is coalesced, validated, and refined. The team approach helps reduce bias.

10. A sound multidisciplinary report needs to include:

    a. A summary of the elements of assessment outlined above
    b. An appropriate DSM-IV-TR diagnosis
    c. The team's opinion regarding the doctor's fitness to practice

d. Conclusions and treatment recommendations based on compelling psychological and medical data

8) Treatment:

The central goal of treatment is to help the doctor confront, understand and resolve the issues that predisposed him/her to professional sexual misconduct. Treatment is most effective when it is structured around: 1) protecting the sanctity of future doctor-patient relationships; 2) helping the doctor to develop genuine victim empathy; 3) promoting personal and professional growth; and 4) helping doctors to appreciate his/her strengths and gain insight into their vulnerabilities.

Broken down into their component parts, the elements of treatment are most effective when they include:

- An educational component covering professional boundaries and ethics
- Victim empathy exercises
- Cognitive-behavioral interventions
- Psychodynamic/cognitive individual and group psychotherapies
- The writing of a comprehensive sexual misconduct paper
- Psychopharmacology (if indicated)
- Sexual addiction and substance dependence treatment (if indicated)
- Couples/family counseling (if indicated)

a. Education:

The educational component of the treatment should include readings and lectures covering issues related to ethics, the identification of professional boundaries, transference/ countertransference dynamics and an examination of the research documenting the painful consequences of violating the sanctity of the doctor-patient relationship. The educational process is most effective when it occurs within the context of biweekly individual meetings and in-group sessions with other doctors who are struggling with similar difficulties.

b. Victim Empathy:

Victim empathy is not something that can be learned. It is a felt experience -- one that emerges within the context of mapping out one's personal emotional terrain. The presence of shame sharply reduces the prospect that the doctor will be able to experience genuine empathy and remorse. This is because shame is often associated with uncomfortable feelings of vulnerability and helplessness – particularly within the doctor-as-patient population. To address this dilemma, we help the doctor to mine for these kinds of uncomfortable emotions within a collegial atmosphere of mutual trust so that victim empathy can emerge within the context of making a connection with one's emotions – a formidable task for some. Various forms of psychotherapy can help doctors to step into the shoes of their victim(s), but

more often than not, victim empathy emerges as a byproduct of being fully engaged in a compassionate treatment community over time.

b. Psychodynamic/Cognitive Individual and Group Psychotherapies:

Psychodynamic and cognitive psychotherapy sessions are a daily part of the doctor's experience at PRC. These individual and group sessions (with other health professionals who have violated patient boundaries) are structured around helping the patient population to relax their defenses of narcissism and intellectualization in order to explore their internal world and behaviors with less shame and resistance. Cognitive psychotherapy techniques are employed to help each doctor challenge dysfunctional and distorted patterns of thinking that can predispose them to lines of thinking that can evoke dysphoric mood states and undermine sound judgment.

c. Sexual Misconduct Paper:

The writing of a comprehensive sexual misconduct paper is a very important part of the treatment process. The goal of having the doctor write this paper is threefold:

- To help the doctor internalize the knowledge, skills and insight gleaned over the course of treatment
- To gain insight into those internal states of mind (i.e., feelings, fantasies and lines of thinking) that predisposed them to episodes of sexual misconduct in the past
- To internalize the knowledge, skill and ability needed to prevent future episodes of sexual misconduct or boundary crossing

The writing of the sexual misconduct paper starts with the doctor documenting (in an unedited/unpolished manner), the feelings, fantasies and rationalizations that precipitated the doctor's boundary crossings. The doctor is encouraged by staff and peers to not judge the narrative as it unfolds, but to merely reexperience what happened in a truthful manner – to let the story develop in a natural way. We stress that uncovering the truth, although at times painful and frightening, will eventually lead to a less fragmented sense of self and understanding of the dynamics that fueled the sexual misconduct. After completing this first draft and receiving more treatment, the doctor is asked to go back through their narrative and add reflective commentary and insight to sections where their judgment went awry. When making these additions, the doctor is asked to explore the *meanings* that were attached to the feelings, fantasies and rationalizations that preceded their actions.

It is the doctor's writing and understanding of their stories, in combination with daily participation in a treatment process that begins to illuminate more clearly the core issues that precipitated their sexual misconduct. Working within a challenging yet compassionate treatment setting is immensely conducive to facilitating insight, victim empathy, and personal transformation.

d. Psychopharmacology:

Over the course of treatment, it is important for the program psychiatrist to explore any biological issues that might have facilitated the doctor's sexual misconduct. (i.e., an undiagnosed bipolar illness, substance induced psychosis or mania). Additionally, it is not uncommon for some doctors to become depressed or even suicidal after allegations of sexual misconduct are made known to authorities. If indicated, psychopharmacological treatment can be an important component of the treatment process.

e. Sexual Addiction and Substance Dependence Treatment:

Occasionally, a doctor's sexual misconduct is complicated by addiction. The doctor's addiction issues can be related to sex, pornography, Internet activities, substances or a combination thereof. When addiction problems color the landscape of the sexual misconduct, a dual treatment program needs to be made available to the doctor.

f. Couples/family counseling (if indicated):

In order to support spouses and families during the doctor's crisis, the treatment team can encourage concerned members of the doctor's family to participate in certain aspects of his/her treatment program. Individual and couples therapies can be offered to the spouse, as well as the opportunity to participate in a thorough analysis of the spousal relationship to help disentangle core conflicts and blocked empathy.

9) Prerequisites for professional reentry:

Before a reentry plan can be drafted, the multidisciplinary team should review the prerequisites for professional reentry:

a. The successful completion of a comprehensive assessment and primary intensive day or residential treatment.

b. The doctor is able to genuinely understand and acknowledge that he/she was fully responsible for engaging in professional sexual misconduct; and that his/her misconduct was rooted in an untreated psychological/medical condition.

c. Genuine remorse for unethical actions.

d. An internalized and well-integrated understanding of professional boundaries and sound ethics.

e. A greater capacity to feel and identify emotions so that genuine empathy and remorse can become an integrated part of the doctor's professional and personal life.

f. A resolution of the cognitive distortions (rationalizations) that fueled the doctor's professional sexual misconduct so that the occurrence of future boundary violations can be prevented.

g. Behavioral skills have been internalized to effectively manage any future temptations.

h. The assessment/treatment team has established to a reasonable degree of medical/psychological certainty that the doctor's risk to reoffend is estimated to be no greater than the general physician population.

i. Agreement by the doctor to continue to obtain professional help for his/her psychosexual disorder and/or any other problems including periodic reassessment by the team with whom he/she was originally assessed.

j. The boundaries within which the doctor will be able to practice with skill and safety have been identified (e.g., the use of a chaperone, practice monitor, patient satisfaction surveys, periodic polygraph tests).

k. The doctor has developed a robust relapse prevention plan.

l. A draft of a reasonable reentry plan has been developed.

m. Professional monitoring and accountability arrangements have been made with appropriate parties.

Our experience shows us that an interrupted treatment process produces the best outcome. We find that an initial 6-8 weeks of intensive day treatment, followed by individual psychotherapy at home, as well as return visits to PRC over time provides the kind of support doctors need to manage the emotional, legal and familial crises that follow professional sexual misconduct.

The reentry plan and the nature of restrictions when indicated:

a. The development of a reentry plan that is negotiated between the doctor, the PRC treatment team and the doctor's rehabilitation coordinator.

b. The doctor has identified a mentor to monitor his/her practice. The practice monitor agrees to oversee the doctor's practice: For example, through direct observation or via staff observations; an open door policy; the regular use of a chaperone; restrictions regarding same or opposite sex examination or treatment (if indicated); anonymous, random patient satisfaction surveys, chart review, etc.

c. The doctor will need to facilitate communication between concerned parties (the Board, therapists, mentor, etc.) by signing appropriate releases of information.

d. The establishment of a strict code of professional conduct that will be used in the office. This should be put in writing and distributed amongst all staff and reviewed on a periodic basis.

e. The doctor will complete any continuing education deemed necessary as a result of his/her absence from professional practice.

f. The establishment of a solid recovery network of health and accountability (friends, a psychotherapist, 12-step program, and state/privately-funded recovery/monitoring program (if possible).

g. If substances of abuse were associated in any way with past professional sexual misconduct, the doctor must refrain from using these substances and submit to random drug/alcohol screening.